

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0033977</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Atrium Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1425 Estes Avenue</u> <u>Chicago</u> <u>60626</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(773) 973-4780</u> <b>Fax #</b> <u>(773) 973-1895</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
<b>IDPA ID Number:</b> <u>363589582001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>00/00/88</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>160</u>	Skilled (SNF)	<u>160</u>	<u>58,400</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>160</u>	TOTALS	<u>160</u>	<u>58,400</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,389</u>	<u>870</u>	<u>543</u>	<u>14,802</u>	8
9	SNF/PED					9
10	ICF	<u>36,437</u>	<u>789</u>	<u>196</u>	<u>37,422</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>49,826</u>	<u>1,659</u>	<u>739</u>	<u>52,224</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 89.42%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 07/01/88 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 20 and days of care provided 543Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/03

Ending:

12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	227,670	44,194	13,468	285,332		285,332		285,332		1
2	Food Purchase		200,393		200,393	(32,025)	168,368	(64)	168,304		2
3	Housekeeping	208,217	35,158		243,375		243,375		243,375		3
4	Laundry	57,252	14,162		71,414		71,414		71,414		4
5	Heat and Other Utilities			114,360	114,360		114,360	2,205	116,565		5
6	Maintenance	34,572	20,351	49,634	104,557		104,557	(14,685)	89,872		6
7	Other (specify):*							873	873		7
8	<b>TOTAL General Services</b>	527,711	314,258	177,462	1,019,431	(32,025)	987,406	(11,671)	975,735		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,250	5,250		5,250		5,250		9
10	Nursing and Medical Records	1,294,098	48,141	7,008	1,349,247		1,349,247	(4,230)	1,345,017		10
10a	Therapy	35,788		2,883	38,671		38,671		38,671		10a
11	Activities	51,743	4,767	1,644	58,154		58,154		58,154		11
12	Social Services	66,644		3,312	69,956		69,956		69,956		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,448,273	52,908	20,097	1,521,278		1,521,278	(4,230)	1,517,048		16
	<b>C. General Administration</b>										
17	Administrative	77,684		244,800	322,484		322,484	(106,728)	215,756		17
18	Directors Fees										18
19	Professional Services			51,761	51,761		51,761	(21,832)	29,929		19
20	Dues, Fees, Subscriptions & Promotions			19,289	19,289		19,289	(8,295)	10,994		20
21	Clerical & General Office Expenses	135,019	75,528	381,906	592,453		592,453	(349,926)	242,527		21
22	Employee Benefits & Payroll Taxes			309,233	309,233	32,025	341,258		341,258		22
23	Inservice Training & Education										23
24	Travel and Seminar			910	910		910	743	1,653		24
25	Other Admin. Staff Transportation			1,579	1,579		1,579	2,397	3,976		25
26	Insurance-Prop.Liab.Malpractice			151,495	151,495		151,495	3,325	154,820		26
27	Other (specify):*							31,035	31,035		27
28	<b>TOTAL General Administration</b>	212,703	75,528	1,160,973	1,449,204	32,025	1,481,229	(449,281)	1,031,949		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,188,687	442,694	1,358,532	3,989,913		3,989,913	(465,182)	3,524,731		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Atrium Health Care Center

#0033977

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			62,589	62,589		62,589	12,173	74,762			30
31	Amortization of Pre-Op. & Org.							3,912	3,912			31
32	Interest			8,286	8,286		8,286	198,654	206,940			32
33	Real Estate Taxes			185,058	185,058		185,058	9,863	194,921			33
34	Rent-Facility & Grounds			564,610	564,610		564,610	(564,610)	0			34
35	Rent-Equipment & Vehicles							6,910	6,910			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			820,543	820,543		820,543	(333,097)	487,446			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,946	146,324	164,270		164,270		164,270			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		17,946	233,924	251,870		251,870		251,870			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,188,687	460,640	2,412,999	5,062,326		5,062,326	(798,279)	4,264,047			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Atrium Health Care Center

# 0033977

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(125,711)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(381,482)	21		24
25	Fund Raising, Advertising and Promotional	(400)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,295)	20		28
29	Other-Attach Schedule	(76,800)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (589,752)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(208,527)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (208,527)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (798,279)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Atrium Health Care Center			
ID# 0023977			
Report Period Beginning:	01/01/03		
Ending:	12/31/03		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 Miscellaneous Income	\$ (4,950)	21	1
2 R.U.C. CPE	(2,500)	20	2
3 Interest Income	(9,459)	32	3
4 Pharmacy - VA	(4,230)	10	4
5 Bank Charges	(60)	22	5
6 Political Contributions	(50)	20	6
7 IL Replacement Tax	(5,849)	21	7
8 Capitalized R&M	(25,124)	00	8
9 Seminar Expense	300	22	9
10 R.O.H. Replacement Tax	(1,713)	21	10
11 R.O Miscellaneous Income	(24)	25	11
12 Prior Period Legal	(1,900)	19	12
13 Non-allowable Legal	(21,450)	19	13
14			14
15			15
16			16
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95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(76,800)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(64)											(64)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,205									2,205	5
6	Maintenance	(25,134)		2,799	7,650								(14,685)	6
7	Other (specify):*				873								873	7
8	<b>TOTAL General Services</b>	<b>(25,198)</b>		<b>5,004</b>	<b>8,523</b>								<b>(11,671)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(4,230)											(4,230)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(4,230)</b>											<b>(4,230)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(214,571)	107,843								(106,728)	17
18	Directors Fees													18
19	Professional Services	(23,438)		1,606									(21,832)	19
20	Fees, Subscriptions & Promotions	(8,295)											(8,295)	20
21	Clerical & General Office Expenses	(393,721)	1,692	42,088		15							(349,926)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	300		443									743	24
25	Other Admin. Staff Transportation			2,397									2,397	25
26	Insurance-Prop.Liab.Malpractice			2,695		630							3,325	26
27	Other (specify):*			25,781	5,254								31,035	27
28	<b>TOTAL General Administration</b>	<b>(425,154)</b>	<b>1,692</b>	<b>(139,561)</b>	<b>113,097</b>	<b>645</b>							<b>(449,281)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(454,582)</b>	<b>1,692</b>	<b>(134,557)</b>	<b>121,620</b>	<b>645</b>							<b>(465,182)</b>	<b>29</b>





Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 564,610	Atrium HealthCare Ltd. Partnership		\$	(564,610)	1
2	V	32 Mortgage Interest		Atrium HealthCare Ltd. Partnership		202,918	202,918	2
3	V	30 Depreciation		Atrium HealthCare Ltd. Partnership		114,375	114,375	3
4	V	31 Amortization		Atrium HealthCare Ltd. Partnership		3,912	3,912	4
5	V	21 IL Replacement Tax		Atrium HealthCare Ltd. Partnership		1,713	1,713	5
6	V	21 Miscellaneous	21	Atrium HealthCare Ltd. Partnership			(21)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 564,631			\$ 322,918	\$ * (241,713)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 2,205	\$ 2,205
16	V	6 REPAIRS AND MAINT.				2,799	2,799
17	V	10 REHABILITATION CONS.					
18	V	17 ADMIN. SAL.-NON OWNER				30,229	30,229
19	V	19 PROFESSIONAL FEES				1,606	1,606
20	V	20 DUES, SUBSCRIPTIONS					
21	V	21 CLERICAL & GENERAL				42,088	42,088
22	V	24 SEMINARS				443	443
23	V	25 ADMIN. STAFF TRAVEL				2,397	2,397
24	V	26 INSURANCE				2,695	2,695
25	V	27 EMPLOYEE BENEFITS				25,781	25,781
26	V	30 DEPRECIATION				19,050	19,050
27	V	32 INTEREST				451	451
28	V	34 BUILDING RENT				17,578	17,578
29	V	35 EQUIPMENT RENTAL				6,910	6,910
30	V						
31	V	17 Manaagement Fees	244,800				(244,800)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 244,800			\$ 154,232	\$ * (90,568)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$	\$
16	V	6 MAINT. COMP. - NON-OWNER				7,650	7,650
17	V	7 EMP. BEN. - S. WEBSTER					
18	V	7 EMP. BEN. - MAINT. NON-OWNER				873	873
19	V	17 ADMIN. COMP - H. WENGROW				21,702	21,702
20	V	17 ADMIN. COMP - J. WEBSTER				86,141	86,141
21	V	27 EMP. BEN. - H. WENGROW				1,031	1,031
22	V	27 EMP. BEN. - J. WEBSTER				4,223	4,223
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 121,620	\$ * 121,620

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 CLERICAL	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 15	\$ 15
16	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		630	630
17	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		4,459	4,459
18	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		4,744	4,744
19	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		9,863	9,863
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V	34 RENT	17,578	DOUBLE YOU REALTY, LLC			(17,578)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,578			\$ 19,711	\$ * 2,133

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Howard Wengrow	Owner	Administrative	25.31%	See Attached	6.00	9.23%	Sal. Staycare	\$ 21,702	17-7	1
2	Jeff Webster	Owner	Administrative	25.31%	See Attached	25.00	38.46%	Sal. Staycare	86,142	17-7	2
3	Yeruchom Levovitz	Administrator	Administrative	0%	See Attached	40.00	100.00%	Salary	40,769	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 148,613		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization STAYCARE MANAGEMENT, LTD.Street Address 3737 W ARTHUR AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (847) 679-2121Fax Number (847) 679-2122

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	179,600	5	\$ 7,581	\$	52,224	\$ 2,205	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	179,600	5	9,625		52,224	2,799	2
3	10 REHABILITATION CONS.	PATIENT DAYS	179,600	5			52,224		3
4	17 ADMIN. SAL.-NON OWNER	PATIENT DAYS	179,600	5	103,960	103,960	52,224	30,229	4
5	19 PROFESSIONAL FEES	PATIENT DAYS	179,600	5	5,522		52,224	1,606	5
6	20 DUES, SUBSCRIPTIONS	PATIENT DAYS	179,600	5			52,224		6
7	21 CLERICAL & GENERAL	PATIENT DAYS	179,600	5	144,742	137,677	52,224	42,088	7
8	24 SEMINARS	PATIENT DAYS	179,600	5	1,525		52,224	443	8
9	25 ADMIN. STAFF TRAVEL	PATIENT DAYS	179,600	5	8,244		52,224	2,397	9
10	26 INSURANCE	PATIENT DAYS	179,600	5	9,270		52,224	2,695	10
11	27 EMPLOYEE BENEFITS	PATIENT DAYS	179,600	5	88,663		52,224	25,781	11
12	30 DEPRECIATION	PATIENT DAYS	179,600	5	65,514		52,224	19,050	12
13	32 INTEREST	PATIENT DAYS	179,600	5	1,549		52,224	451	13
14	34 BUILDING RENT	PATIENT DAYS	179,600	5	60,450		52,224	17,578	14
15	35 EQUIPMENT RENTAL	PATIENT DAYS	179,600	5	23,765		52,224	6,910	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 530,410	\$ 241,637		\$ 154,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977 Report Period Beginning: 01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization STAYCARE MANAGEMENT, LTD.Street Address 3737 W ARTHUR AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (847) 679-2121Fax Number (847) 679-2122

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	11,983	11,983			1
2	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	12	7,650	2
3	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,612				3
4	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	3,001		12	873	4
5	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	235,100	235,100	6	21,702	5
6	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	223,967	223,967	25	86,141	6
7	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	11,174		6	1,031	7
8	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	10,979		25	4,223	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 524,126	\$ 497,360		\$ 121,620	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DOUBLE YOU REALTY, LLCStreet Address 3737 W. ARTHUR AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (847) 679-2121Fax Number (847) 679-2122

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21 CLERICAL	PATIENT DAYS	179,600	5	\$ 52	\$	52,224	\$ 15	1
2	26 INSURANCE	PATIENT DAYS	179,600	5	2,166		52,224	630	2
3	30 DEPRECIATION	PATIENT DAYS	179,600	5	15,335		52,224	4,459	3
4	32 INTEREST EXPENSE	PATIENT DAYS	179,600	5	16,315		52,224	4,744	4
5	33 REAL ESTATE TAXES	PATIENT DAYS	179,600	5	33,918		52,224	9,863	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 67,786	\$		\$ 19,711	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Allocated From Atrium Partnership		X	Mortgage - MB Financial			\$	2,242,744			\$	202,918	1	
2	Allocated From Staycare		X									451	2	
3	Allocated From Double You		X	Mortgage - MB Financial								4,744	3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Due On Insurance		X	Prepaid Insurance				170,212				8,286	6	
7													7	
8	See Supplemental Schedule												8	
9	TOTAL Facility Related						\$	2,412,956				\$	216,399	9
	B. Non-Facility Related*													
10													10	
11	Interest Income		X									(9,459)	11	
12													12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(9,459)	14
15	TOTALS (line 9+line14)						\$	2,412,956				\$	206,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

						<b><i>Important</i></b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$																									
1. Real Estate Tax accrual used on 2002 report.								\$	186,367	1																							
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)								\$	192,830	2																							
3. Under or (over) accrual (line 2 minus line 1).								\$	6,463	3																							
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)								\$	188,457	4																							
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>								\$		5																							
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																																	
<b>TOTAL REFUND \$                  For                  Tax Year.      (Attach a copy of the real estate tax appeal board's decision.)</b>								\$		6																							
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								\$	194,920	7																							
Real Estate Tax History:																																	
Real Estate Tax Bill for Calendar Year:		1998	199,899	8	<table border="1"> <thead> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td></td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td></td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td></td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td></td> <td>16</td> </tr> </tbody> </table>						FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$		13	14	PLUS APPEAL COST FROM LINE 5	\$		14	15	LESS REFUND FROM LINE 6	\$		15	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
FOR OHF USE ONLY																																	
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13																													
14	PLUS APPEAL COST FROM LINE 5	\$		14																													
15	LESS REFUND FROM LINE 6	\$		15																													
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16																													
		1999	198,557	9																													
		2000	176,352	10																													
		2001	180,939	11																													
		2002	182,967	12																													
<b>2003 Accrual = 182,967 x 1.03% = 188,457 Rounded</b>																																	

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-32-105-005</u>	<u>Long Term Care Property</u>	\$ <u>2,476.00</u>	\$ <u>2,476.00</u>
2. <u>11-32-105-006</u>	<u>Long Term Care Property</u>	\$ <u>45,880.00</u>	\$ <u>45,880.00</u>
3. <u>11-32-105-007</u>	<u>Long Term Care Property</u>	\$ <u>88,938.00</u>	\$ <u>88,938.00</u>
4. <u>11-32-105-008</u>	<u>Long Term Care Property</u>	\$ <u>45,673.00</u>	\$ <u>45,673.00</u>
5. <u>10-35-329-014</u>	<u>Home Office Property</u>	\$ <u>33,633.68</u>	\$ <u>9,779.98</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>216,600.68</u>	\$ <u>192,746.98</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,313

B. General Construction Type: Exterior Brick Frame

Number of Stories 3

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 3,912

4. Dates Incurred:

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		26,895	1972	\$ 124,712	1
2				14,539	2
3	TOTALS	26,895		\$ 139,251	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XL OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1972		50,343		20	-		-	9
10	Various		1974		12,941		20	-		-	10
11	Various		1977		46,500		20	-		-	11
12	Various		1978		23,362		20	-		-	12
13	Various		1979		11,676		20	-		1,354	13
14	Various		1980		12,652		20	-		580	14
15	Various		1981		4,095		20	-		393	15
16	Various		1982		1,310		20	-		1,310	16
17	Various		1989		42,200		20	2,110	2,110	24,194	17
18	Various		1992		16,375		20	819	819	8,567	18
19	Various		1993		26,090		20	1,305	1,305	12,130	19
20	Various		1995		32,183		20	1,610	1,610	13,095	20
21	Various		1996		71,604		20	3,581	3,581	27,151	21
22	Various		1997		52,684		20	2,636	2,636	17,506	22
23	Various		1998		131,108		20	6,557	6,557	37,028	23
24	Various		1999		15,353		20	769	769	3,516	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		919,825	114,375		26,504	(87,871)	627,862	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		145,778	7,384		3,814	(3,570)	3,814	68
69	Financial Statement Depreciation			10,997			(10,997)		69
70	TOTAL (lines 4 thru 69)		\$ 1,616,079	\$ 132,756		\$ 49,705	\$ (83,051)	\$ 778,500	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,616,079	\$ 132,756		\$ 49,705	\$ (83,051)	\$ 778,500	1
2	Nurses Station	2000	19,894		20	510	510	1,679	2
3	Elevator	2000	23,535		20	603	603	2,388	3
4	Pavement Work	2000	12,773		20	983	983	3,927	4
5	Cubicle Curtains	2000	680		20	34	34	128	5
6	Pa Service & Repair	2000	887		20	44	44	166	6
7	Generator	2000	629		20	31	31	115	7
8	Fire Alarm System	2000	770		20	39	39	142	8
9	Pavement Work	2000	1,190		20	60	60	204	9
10	Nurse Call System	2000	1,160		20	58	58	198	10
11	Sprinkler Svstem	2000	2,428		20	121	121	404	11
12	Generator	2000	3,200		20	160	160	520	12
13	Nurse Stations	2000			20				13
14	Fire Dampers	2000	804		20	40	40	157	14
15	Air Vents	2000	3,207		20	160	160	628	15
16	Border	2001	965		20	48	48	117	16
17	Corridor Lights	2001	996		20	50	50	125	17
18	Drywall/Faucet Instl	2001	3,170		20	159	159	397	18
19	Heat Detector Replmn	2001	556		20	28	28	72	19
20	Border	2001	1,550		20	78	78	194	20
21	Water Work	2001	5,000		20	250	250	729	21
22	Water Fountain	2001	773		20	39	39	110	22
23	Phone System	2002	536		20	54	54	98	23
24	Install Control Cabinet	2002	923		20	92	92	162	24
25	Phone System	2002	510		20	51	51	85	25
26	Telephone Service	2002	744		20	74	74	118	26
27	Pc Motor	2002	1,217		20	122	122	172	27
28	Ceiling	2002	741		20	74	74	130	28
29	Refrigerant	2002	888		20	91	91	128	29
30	Dble-Blwr W	2002	527		20	53	53	75	30
31	Phone System	2002	760		20	76	76	114	31
32	Coridor Bumpers	2003	5,861		20	488	488	488	32
33	Wallcoverings	2003	6,332		20	3,694	3,694	3,694	33
34	TOTAL (lines 1 thru 33)		\$ 1,719,285	\$ 132,756		\$ 58,069	\$ (74,687)	\$ 796,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,719,285	\$ 132,756		\$ 58,069	\$ (74,687)	\$ 796,164	1
2	Lights	2003	4,965		20	290	290	290	2
3	Fence	2003	8,145		20	475	475	475	3
4	Nurses Staition	2003	6,010		20	351	351	351	4
5	Security System	2003	6,500		20	542	542	542	5
6	Door Svsstem	2003	6,379		20	372	372	372	6
7	Hvac	2003	1,820		20	83	83	83	7
8	Paint	2003	917		20	42	42	42	8
9	Hvac	2003	1,012		20	38	38	38	9
10	Hvac	2003	828		20	31	31	31	10
11	Hvac	2003	907		20	26	26	26	11
12	Nurses' Station Remodel	2003	6,010		20	175	175	175	12
13	Elevator Repair	2003	635		20	19	19	19	13
14	Paint	2003	643		20	16	16	16	14
15	Alarm Equipment	2003	723		20	12	12	12	15
16	Security Door Device	2003	987		20	8	8	8	16
17	Patient Rooms Remodel	2003	7,497		20	219	219	219	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,773,263	\$ 132,756		\$ 60,768	\$ (71,988)	\$ 798,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1972	\$ 574,854	\$ 114,375		\$ 26,504	\$ (87,871)	\$ 627,862	4
5				1972	344,971						5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 919,825	\$ 114,375		\$ 26,504	\$ (87,871)	\$ 627,862	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation From Double You			2003	\$ 138,973	\$ 3,420		\$ 3,474	\$ 54	\$ 3,474	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Staycare Management				6,805	3,964		340	(3,624)	340	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.
 See Page 12A-REP, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 145,778	\$ 7,384		\$ 3,814	\$ (3,570)	\$ 3,814	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 49,824	\$ 97	\$ 5,010	\$ 4,913	10	\$ 29,692	71
72	Current Year Purchases	68,864	59,479	7,821	(51,658)	10	7,821	72
73	Fully Depreciated Assets	332,036				10	332,036	73
74								74
75	TOTALS	\$ 450,724	\$ 59,576	\$ 12,831	\$ (46,745)		\$ 369,549	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2003 CHEVY YUKON		\$ 8,141	\$ 8,141	\$ 1,163	\$ (6,978)	5	\$ 1,163	76
77										77
78										78
79										79
80	TOTALS			\$ 8,141	\$ 8,141	\$ 1,163	\$ (6,978)		\$ 1,163	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,371,379	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,473	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,762	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (125,711)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,169,575	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,910 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 53,237	\$		\$ 53,237	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,387			6,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			86,700			86,700	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				17,920		17,920	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						26		26	13
14	TOTAL			\$		\$ 146,324	\$ 17,946		\$ 164,270	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 963,746	\$ 963,760	1
2	Cash-Patient Deposits	47,180	47,180	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	442,002	442,002	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	183,962	183,962	6
7	Other Prepaid Expenses	875	875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>	975	975	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,638,740	\$ 1,638,754	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		260,000	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	360,042	360,042	15
16	Equipment, at Historical Cost	176,982	656,982	16
17	Accumulated Depreciation (book methods)	(248,746)	(1,915,387)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>		62,594	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 288,278	\$ 3,884,854	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,927,018	\$ 5,523,608	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 61,159	\$ 61,158	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,051	47,051	28
29	Short-Term Notes Payable	170,212	170,212	29
30	Accrued Salaries Payable	112,570	112,570	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,457	188,457	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,426	20,426	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	71,935	34,499	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 671,810	\$ 634,373	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,242,744	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 2,242,744	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 671,810	\$ 2,877,117	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,255,208	\$ 2,646,491	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,927,018	\$ 5,523,608	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,645,284</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,645,284</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>409,924</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(800,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (390,076)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,255,208</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,839,892	1
2	Discounts and Allowances for all Levels	(135,235)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,704,657	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	720,859	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 720,859	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,428	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	629	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,622	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 32,679	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	9,459	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,459	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	4,596	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,596	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,472,250	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,019,431	31
32	Health Care	1,521,278	32
33	General Administration	1,449,204	33
	<b>B. Capital Expense</b>		
34	Ownership	820,543	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	164,270	35
36	Provider Participation Fee	87,600	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,062,326	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	409,924	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 409,924	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/03Ending: 12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,009	2,288	\$ 80,131	\$ 35.02	1
2	Assistant Director of Nursing	717	779	25,304	32.48	2
3	Registered Nurses	10,720	12,003	260,716	21.72	3
4	Licensed Practical Nurses	21,119	23,646	447,610	18.93	4
5	Nurse Aides & Orderlies	46,402	49,137	422,869	8.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,489	4,067	35,788	8.80	8
9	Activity Director	1,635	1,816	15,523	8.55	9
10	Activity Assistants	4,442	4,638	36,220	7.81	10
11	Social Service Workers	6,866	7,268	66,644	9.17	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,152	33,135	15.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,546	22,541	194,535	8.63	15
16	Dishwashers					16
17	Maintenance Workers	2,759	3,040	34,572	11.37	17
18	Housekeepers	27,112	29,220	208,217	7.13	18
19	Laundry	7,161	7,523	57,252	7.61	19
20	Administrator	2,752	3,032	77,684	25.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,669	8,830	135,019	15.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,001	4,377	57,468	13.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	170,371	186,357	\$ 2,188,687 *	\$ 11.74	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,168	01-03	35
36	Medical Director	Monthly	5,250	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,880	10-03	39
40	Physical Therapy Consultant	43	2,196	10a-03	40
41	Occupational Therapy Consultant	5	237	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	450	10a-03	43
44	Activity Consultant	44	1,644	11-03	44
45	Social Service Consultant	64	3,312	12-03	45
46	Other(specify)				46
47	Dietary Chaplain	Monthly	3,300	01-03	47
48					48
49	TOTAL (lines 35 - 48)	165	\$ 33,565		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Mickey Vujanovic 01/01-07/07/03	Administrator	0	\$ 36,915	Workers' Compensation Insurance		\$ 33,064	IDPH License Fee	\$
Yeruchom Levovitz 07/08-12/31/03	Administrator	0	40,769	Unemployment Compensation Insurance		14,744	Advertising: Employee Recruitment	992
				FICA Taxes		165,682	Health Care Worker Background Check (Indicate # of checks performed 44 )	440
				Employee Health Insurance		70,932	Yellow Page Advertising	5,295
				Employee Meals		32,025	Licenses/Permits/Fees	2,212
				Illinois Municipal Retirement Fund (IMRF)*			ICLTC Dues	9,900
				City Employee Head Tax		4,496	ICLTC COPE	(2,550)
				Employee Benefits		3,032		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,684	Union Pension Expense		14,017		
B. Administrative - Other				401K-Employer		3,266		
Description			Amount					
Management Fee			\$ 244,800				Less: Public Relations Expense	(
							Non-allowable advertising	(
							Yellow page advertising	(5,295)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 244,800	TOTAL (agree to Schedule V, line 22, col.8)		\$ 341,258	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,994
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost,Ruttenberg&Rothblatt	Accounting		\$ 20,225			\$	Out-of-State Travel	\$
Caronia Corporation	Legal		1,950					
Sachnoff & Weaver	Legal		23,619				In-State Travel	
Querrey & Harrow	Legal		5,000					
Personnel Planners	Unemployment Constl.		967					
							Seminar Expense	1,210
							Allocated Staycare	443
							Entertainment Expense	(
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 51,761	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,653

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

STATE OF ILLINOIS

# 0033977

Report Period Beginning:

01/01/03

Ending:

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12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$9,900
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,075 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 87,600  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 32,025 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.